Brad R. Kaplan, D.M.D., LLC

Oral, Maxillofacial and Implant Surgical Care

HIPAA Notice of Privacy Practices

The Notice of Privacy Practices describes how we may use and disclose your **protected health information (PHI)** in order to carry out treatment, payment or other health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present and/or future physical or mental health or condition and related health care services.

In order for us to release your PHI to anyone other than yourself, authorized treating practitioners, and your medical insurance provider, we must obtain your authorization for access by others. It is understood that **Dr. Brad Kaplan** may also request pertinent medical information from other practitioners and facilities in order to help safely and fully complete your diagnosis.

Please check all situations below where you would grant the individuals listed below access to your PHI:

_____ **Pick-up of medical records. (Films, CDs, reports)**
_____ **Billing information**

List the last 4 digits of your SSN _____

Please list individuals (i.e., spouse or other family member) for whom you authorize access to your PHI:

Name _____ **Relationship** _____

Name _____ **Relationship** _____

Name _____ **Relationship** _____

By submitting this form, I hereby permit Dr. Brad Kaplan to disclose my PHI to the individual(s) indicated above. I understand that each individual listed will be required to provide the last 4 digits of my SSN I have given in order to release my PHI. In addition, authorized individual(s) must present identification as proof that they are who they claim to be. I also understand that Dr. Brad Kaplan reserves the right to deny access. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any objections with this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main number.

Signature below is acknowledgement that you have received our Notice of Privacy Practices.

Name: _____ Signature: _____ Date: _____

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